William H. Gamage, Esq.
Nevada Bar No. 9024
GAMAGE & GAMAGE
5580 South Fort Apache Street, Suite 110
Las Vegas, Nevada 89148
PH: (702) 386-9529
FX: (702) 382-9529
Attorney for Defendant Makyl Haggerty

UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

UNITED STATES OF AMERICA Plaintiff, vs. MAKYL HAGGERTY, et al. Defendant.	CASE NO.: 2:12-CR-00004-APG-GWF **DEFENDANT'S SENTENCING MEMORANDUM** **Hearing Date: 08/21/2014** **Hearing Time: 10:00 A.M.**

COMES NOW, Defendant MAKYL HAGGERTY (hereinafter "HAGGERTY") by and through counsel of record William H. Gamage, Esq. of Gamage & Gamage and hereby files this SENTENCING MEMORANDUM in the above titled matter.

SENTENCING MEMORANDUM

Defendant HAGGERTY is scheduled to be sentenced on Aug 21, 2014 by this Honorable Court on the charge of Participation in a Racketeer Influenced Corrupt Organization (RICO); 18 U.S.C. § 1962(c) and § 1963. After his initial arraignment, HAGGERTY was detained and has remained detained since October of 2012.

Based upon the circumstances of this case, we respectfully ask the court to give HAGGERTY the benefit of his plea agreement. Notwithstanding the terms of the guilty plea agreement, counsel for HAGGERTY offers the following information in order for the Court to make an individualized assessment to determine the sentence sufficient but not greater than necessary to fulfill the purposes of sentencing:

OBJECTIONS

Counsel met with Defendant Haggerty after having mailed him a copy of his Presentence Report ("PSR") for purposes of review and approval. Counsel went through the document paragraph by paragraph with Defendant HAGGERTY revealing the following objections and or requests for correction:

- ¶ 68 – 'Oxycodone' should read 'Oxycontin'. Oxycodone hydrochloride is an opioid painkiller. It can be found in a number of prescription medications. When it is available by itself, it is available in the form of Oxycontin. Oxycodone is also found in combination with other ingredients in a number of prescription medications (e.g. Percocet). The main difference between the two relates to the onset of action. Oxycontin is a time released drug. This means that it acts over a period of time. Usually, Oxycodone medications need to be taken every four to six hours. However, Oxycontin continues acting for at least 12 hours. That is why it needs to be taken only twice a day.

I. HAGGERTY SUFFERS FROM MENTAL ILLNESSES WHICH HAVE AFFECTED HIS ABILITY TO MAKE POSITIVE CHOICES THOUGHOUT HIS LIFE:

Based upon medical records received from two facilities and HAGGERTY's interview with US Probation, Makyl suffers from bi-polar disorder, anxiety disorder, and hypertension. Bi-polar disorder is associated with mood swings that range from deep depression to manic mood highs. DEF01. In the manic high phase, those affected exhibit poor judgment, inflated self-esteem, risky behavior, and even the abuse or dangerous use of drugs and alcohol. *Id*. In the depressive phase, sufferers experience anxiety, sleep problems, problems concentrating, and even chronic pain without a known cause. DEF01 – DEF02. Bi-polar disorder is a long term mental health impairment that while very disruptive of a person's life can be treated with controlled medications

and counseling. DEF02.

Pre-arrest records received from West Berkley Family Practice indicate that HAGGERTY suffered from anxiety issues well before his arrest. The report from his January 19, 2012 visit indicates that HAGGERTY had suffered anxiety attacks "for a long time" and that he occasionally took Xanax to relieve symptoms. DEF010.

Post-arrest records indicate that HAGGERTY was treated for anxiety disorder, bi-polar disorder, depression and hypertension at Nevada Southern Detention. DEF011 – DEF027. Over the course of his 18 months of detention, he was prescribed Amlodipine (hypertension management drug) (*See* DEF027 and DEF028 – DEF029); Buspirone (psychotropic drug used to treat anxiety disorder) (*See* DEF027 and DEF030 – DEF031); Fluoxetine (Drug for the treatment of major depressive disorders) (*See* DEF027 and DEF032 – DEF033); Hydroxyzine (anti-anxiety medication) (*See* DEF027 and DEF034 – DEF035); and Lisinopril (hypertension drug) (*See* DEF027 and DEF036 – DEF037).

II. HAGGERTY ENJOYS THE SUPPORT AND BACKING OF HIS FAMILY:

Counsel can attest that HAGGERTY has a loving wife at home (Claudja) that has followed this case very closely and has provided assistance to counsel and Makyl. She has provided vital assistance and support for HAGGERTY in making important decisions and has remained in contact with Makyl and counsel over the last 18 months of this case. Makyl and Claudja have jointly made all important decisions regarding this case and she is prepared to assist Makyl in getting home as soon as possible after completion of his likely sentence of incarceration.

III. HAGGERTY IS A CANDIDATE AND SHOULD COMPLETE DRUG ABUSE COUNSELING – Request RDAP Placement:

HAGGERTY has reported the use or experimentation with illegal drugs for some time in his life. PSR ¶ 67-69. HAGGERTY began abusing alcohol at the age of 16 and soon thereafter transitioned to using marijuana and oxycontin on a regular basis. At 19, HAGGERTY

experimented with and regularly used ecstacy **almost on a daily basis**. *Id*. All of these drugs can have significant adverse affects on the mental health of the user and that person's ability to make sound judgments. HAGGERTY has expressed willingness to participate in drug counseling. Consequently, Makyl would benefit from further drug counseling and respectfully requests placement in a facility that can accommodate enrollment in RDAP.

IV. HAGGERTY REQUESTS PLACEMENT AT FCI LOMPOC IF INCARCERATED:

FCI Lompoc houses male non-violent prisoners, is located somewhat close to his family, and has RDAP and mental health programs. Consequently, while HAGGERTY is aware this Court cannot guarantee placement in this facility, he would ask that it be recommended.

PRAYER FOR LENIENCY

Based upon the above and foregoing, HAGGERTY is contractually bound to recommend the 84 month sentence in the Guilty Plea Agreement as HAGGERTY is a CHC I. PSR ¶ 45. However, this Court can deviate from the terms of the Guilty Plea Agreement in order to craft a sentence sufficient but not greater than necessary to fulfill the purposes of sentencing.

Counsel suggests that a 3 level downward departure might appropriately sentence Makyl taking into consideration his bi-polar disorder, anxiety disorder, depressive disorder and extensive drug abuse problems (that likely stem out of his bi-polar diagnosis).

Makyl is a young man with a limited criminal history. He suffers from the challenges that attend mental health problems and drug abuse. As stated above, bi-polar disorder substantially affects impulse control and the making of positive choices. While Makyl does not believe his mental problems excuse his conduct, the Court should consider this problem in making an individualized sentencing decision for HAGGERTY.

Furthermore, the Court should be aware that Makyl has met with Law enforcement on two separate occasions to explain his conduct and to answer questions about what he did. Moreover,

HAGGERTY agreed to further meetings with the Government to educate law enforcement on his techniques in making false identification cards. Consequently, HAGGERTY has been a cooperative defendant throughout this investigation.

A three (3) level downward departure would affect a substantial opportunity for Makyl to receive drug abuse treatment and to serve an appropriate sentence for his crime.

CONCLUSION

For the foregoing reasons and notwithstanding Defendant's contractual recommendation of 84 months incarceration, an individualized assessment of HAGGERTY should lead to an appropriate sentence of the following:

- A term of 70 months;
- Supervised Release for 3 years;
- No fine;
- Restitution as listed in the PSR, page 26; and,
- A $100 administrative assessment.

DATED THIS 28th day of July, 2014.

GAMAGE & GAMAGE

/s/ William H Gamage, Esq.

William H. Gamage, Esq.
Nevada Bar No. 9024
5580 South Fort Apache Street, Suite 110
Las Vegas, Nevada 89148
PH: (702) 386-9529
FX: (702) 382-9529
Attorney for Defendant Makyl Haggerty

CERTIFCATE OF SERVICE

I hereby certify that on or the 31th day of July, 2014, the above and foregoing SENTENCING MEMORANDUM was served via the Court's electronic filing system on all counsel registered to this case along with Government counsel as follows:

KIMBERLY FRAYN
Assistant United States Attorney
kimberly.frayn@usdoj.gov

ANDREW DUNCAN
Assistant United States Attorney
andrew.duncan@usdoj.gov

JONATHAN OPHARDT
Trial Attorney USDOJ
Jonathan.ophardt@usdoj.gov

/s/ William H. Gamage
EMPLOYEE OF GAMAGE & GAMAGE

MAYO CLINIC

Diseases and Conditions

Bipolar disorder

By Mayo Clinic Staff

Bipolar disorder — sometimes called manic-depressive disorder — is associated with mood swings that range from the lows of depression to the highs of mania. When you become depressed, you may feel sad or hopeless and lose interest or pleasure in most activities. When your mood shifts in the other direction, you may feel euphoric and full of energy. Mood shifts may occur only a few times a year, or as often as several times a day. In some cases, bipolar disorder causes symptoms of depression and mania at the same time.

Although bipolar disorder is a disruptive, long-term condition, you can keep your moods in check by following a treatment plan. In most cases, bipolar disorder can be controlled with medications and psychological counseling (psychotherapy).

Bipolar disorder is divided into several subtypes. Each has a different pattern of symptoms. Types of bipolar disorder include:

- **Bipolar I disorder.** Mood swings with bipolar I cause significant difficulty in your job, school or relationships. Manic episodes can be severe and dangerous.
- **Bipolar II disorder.** Bipolar II is less severe than bipolar I. You may have an elevated mood, irritability and some changes in your functioning, but generally you can carry on with your normal daily routine. Instead of full-blown mania, you have hypomania — a less severe form of mania. In bipolar II, periods of depression typically last longer than periods of hypomania.
- **Cyclothymic disorder.** Cyclothymic disorder, also known as cyclothymia, is a mild form of bipolar disorder. With cyclothymia, hypomania and depression can be disruptive, but the highs and lows are not as severe as they are with other types of bipolar disorder.

The exact symptoms of bipolar disorder vary from person to person. For some people, depression causes the most problems; for other people, manic symptoms are the main concern. Symptoms of depression and symptoms of mania or hypomania may also occur together. This is known as a mixed episode.

Manic phase of bipolar disorder

Signs and symptoms of the manic or hypomanic phase of bipolar disorder can include:

- Euphoria
- Inflated self-esteem
- Poor judgment
- Rapid speech
- Racing thoughts
- Aggressive behavior
- Agitation or irritation
- Increased physical activity
- Risky behavior
- Spending sprees or unwise financial choices
- Increased drive to perform or achieve goals
- Increased sex drive
- Decreased need for sleep
- Easily distracted
- Careless or dangerous use of drugs or alcohol
- Frequent absences from work or school
- Delusions or a break from reality (psychosis)
- Poor performance at work or school

Depressive phase of bipolar disorder

Signs and symptoms of the depressive phase of bipolar disorder can include:

- Sadness
- Hopelessness
- Suicidal thoughts or behavior

DEF01

- Anxiety
- Guilt
- Sleep problems
- Low appetite or increased appetite
- Fatigue
- Loss of interest in activities once considered enjoyable
- Problems concentrating
- Irritability
- Chronic pain without a known cause
- Frequent absences from work or school
- Poor performance at work or school

Other signs and symptoms of bipolar disorder

Signs and symptoms of bipolar disorder can also include:

- **Seasonal changes in mood.** As with seasonal affective disorder (SAD), some people with bipolar disorder have moods that change with the seasons. Some people become manic or hypomanic in the spring or summer and then become depressed in the fall or winter. For other people, this cycle is reversed — they become depressed in the spring or summer and manic or hypomanic in the fall or winter.
- **Rapid cycling bipolar disorder.** Some people with bipolar disorder have rapid mood shifts. This is defined as having four or more mood swings within a single year. However, in some people mood shifts occur much more quickly, sometimes within just hours.
- **Psychosis.** Severe episodes of either mania or depression may result in psychosis, a detachment from reality. Symptoms of psychosis may include false but strongly held beliefs (delusions) and hearing or seeing things that aren't there (hallucinations).

Symptoms in children and adolescents

Instead of clear-cut depression and mania or hypomania, the most prominent signs of bipolar disorder in children and adolescents can include explosive temper, rapid mood shifts, reckless behavior and aggression. In some cases, these shifts occur within hours or less — for example, a child may have intense periods of giddiness and silliness, long bouts of crying and outbursts of explosive anger all in one day.

When to see a doctor

If you have any symptoms of depression or mania, see your doctor or mental health provider. Bipolar disorder doesn't get better on its own. Getting treatment from a mental health provider with experience in bipolar disorder can help you get your symptoms under control.

Many people with bipolar disorder don't get the treatment they need. Despite the mood extremes, people with bipolar disorder often don't recognize how much their emotional instability disrupts their lives and the lives of their loved ones. And if you're like some people with bipolar disorder, you may enjoy the feelings of euphoria and cycles of being more productive. However, this euphoria is always followed by an emotional crash that can leave you depressed, worn out — and perhaps in financial, legal or relationship trouble.

If you're reluctant to seek treatment, confide in a friend or loved one, a health care professional, a faith leader or someone else you trust. They may be able to help you take the first steps to successful treatment.

If you have suicidal thoughts

Suicidal thoughts and behavior are common among people with bipolar disorder. If you or someone you know is having suicidal thoughts, get help right away. Here are some steps you can take:

- Contact a family member or friend.
- Seek help from your doctor, a mental health provider or other health care professional.
- Call a suicide hot line number — in the United States, you can reach the toll-free, 24-hour hot line of the National Suicide Prevention Lifeline at 800-273-8255 to talk to a trained counselor.
- Contact a minister, spiritual leader or someone in your faith community.

When to get emergency help

If you think you may hurt yourself or attempt suicide, call 911 or your local emergency number immediately. If you have a loved one who has harmed himself or herself, or is seriously considering doing so, make sure someone stays with that person. Take him or her to the hospital or call for emergency help.

The exact cause of bipolar disorder is unknown, but several factors seem to be involved in causing and triggering bipolar episodes:

- **Biological differences.** People with bipolar disorder appear to have physical changes in their brains. The significance of these changes is still uncertain but may eventually help pinpoint causes.
- **Neurotransmitters.** An imbalance in naturally occurring brain chemicals called neurotransmitters seems to play a significant role in bipolar disorder and other mood disorders.
- **Hormones.** Imbalanced hormones may be involved in causing or triggering bipolar disorder.
- **Inherited traits.** Bipolar disorder is more common in people who have a blood relative (such as a sibling or parent) with the condition. Researchers are trying to find genes that may be involved in causing bipolar disorder.

- **Environment.** Stress, abuse, significant loss or other traumatic experiences may play a role in bipolar disorder.

Factors that may increase the risk of developing bipolar disorder include:

- Having blood relatives such as a parent or sibling with bipolar disorder
- Periods of high stress
- Drug or alcohol abuse
- Major life changes, such as the death of a loved one
- Being in your early 20s

Conditions that commonly occur with bipolar disorder

If you have bipolar disorder, you may also have another health condition that's diagnosed before or after your diagnosis of bipolar disorder. Such conditions need to be diagnosed and treated because they may worsen existing bipolar disorder. They include:

- **Anxiety disorders.** Examples include post-traumatic stress disorder (PTSD), social phobia and generalized anxiety disorder.
- **Attention-deficit/hyperactivity disorder (ADHD).** ADHD has symptoms that overlap with bipolar disorder. For this reason, bipolar disorder can be difficult to differentiate from ADHD. Sometimes one is mistaken for the other. In some cases, a person may be diagnosed with both conditions.
- **Addiction or substance abuse.** Many people with bipolar disorder also have alcohol, tobacco or drug problems. Drugs or alcohol may seem to ease symptoms, but they can actually trigger, prolong or worsen depression or mania.
- **Physical health problems.** People diagnosed with bipolar disorder are more likely to have certain other health problems, including heart disease, thyroid problems and obesity.

Left untreated, bipolar disorder can result in serious problems that affect every area of your life. These can include:

- Problems related to substance and alcohol abuse
- Legal problems
- Financial problems
- Relationship troubles
- Isolation and loneliness
- Poor work or school performance
- Frequent absences from work or school
- Suicide

You're likely to start by seeing your family doctor or a general practitioner. However, in some cases when you call to set up an appointment, you may be referred immediately to a medical doctor who specializes in diagnosing and treating mental health conditions (psychiatrist).

Because appointments can be brief, and because there's often a lot of ground to cover, it's a good idea to be well prepared for your appointment. Here's some information to help you get ready for your appointment, and know what to expect from your doctor.

What you can do

- **Write down any symptoms you've had,** including any that may seem unrelated to the reason for which you scheduled the appointment.
- **Write down key personal information,** including any major stresses or recent life changes.
- **Make a list of all medications,** vitamins or supplements that you're taking.
- **Take a family member or friend along,** if possible. Sometimes it can be difficult to remember all of the information provided to you during an appointment. Someone who accompanies you may remember something that you missed or forgot.
- **Write down questions to ask** your doctor.

Your time with your doctor may be limited, so preparing a list of questions ahead of time will help you make the most of your time together. For problems related to bipolar disorder, some basic questions to ask your doctor include:

- Do I have bipolar disorder?
- Are there any other possible causes for my symptoms?
- What kinds of tests will I need?
- What treatments are available? Which do you recommend for me?
- What side effects are possible with that treatment?
- What are the alternatives to the primary approach that you're suggesting?
- I have these other health conditions. How can I best manage these conditions together?
- Should I see a psychiatrist or other mental health provider?
- Is there a generic alternative to the medicine you're prescribing me?
- Are there any brochures or other printed material that I can take home with me? What websites do you recommend visiting?

In addition to the questions that you've prepared to ask your doctor, don't hesitate to ask questions during your appointment at any time that you don't understand something.

What to expect from your doctor

Your doctor is likely to ask you a number of questions. Being ready to answer them may reserve time to go over any points you want to spend more time on. Your doctor may ask:

- When did you or your loved ones first begin noticing your symptoms of depression, mania or hypomania?
- How frequently do your moods change?
- Do you ever have suicidal thoughts when you're feeling down?
- How severe are your symptoms? Do they interfere with your daily life or relationships?
- Do you have any blood relatives with bipolar disorder or another mood disorder?
- What other mental or physical health conditions do you have?
- Do you drink alcohol, smoke cigarettes or use street drugs?
- How much do you sleep at night? Does it change over time?
- Do you go through periods when you take risks you wouldn't normally take, such as unsafe sex or unwise, spontaneous financial decisions?
- What, if anything, seems to improve your symptoms?
- What, if anything, appears to worsen your symptoms?

When doctors suspect someone has bipolar disorder, they typically do a number of tests and exams. These can help rule out other problems, pinpoint a diagnosis and also check for any related complications. These can include:

- **Physical exam.** This may involve measuring your height and weight; checking your vital signs, such as heart rate, blood pressure and temperature; listening to your heart and lungs; and examining your abdomen.
- **Lab tests.** These may include blood and urine tests. These tests can help identify any physical problems that could be causing your symptoms.
- **Psychological evaluation.** A doctor or mental health provider will talk to you about your thoughts, feelings and behavior patterns. You may also fill out a psychological self-assessment or questionnaire. With your permission, family members or close friends may be asked to provide information about your symptoms and possible episodes of mania or depression.
- **Mood charting.** To identify exactly what's going on, your doctor may have you keep a daily record of your moods, sleep patterns or other factors that could help with diagnosis and finding the right treatment.

Diagnostic criteria for bipolar disorder

To be diagnosed with bipolar disorder, you must meet the criteria spelled out in the Diagnostic and Statistical Manual of Mental Disorders (DSM). This manual is published by the American Psychiatric Association and is used by mental health providers to diagnose mental conditions and by insurance companies to reimburse for treatment. Diagnostic criteria for bipolar disorder are based on the specific type of bipolar disorder.

- **Bipolar I disorder.** You've had at least one manic or one mixed episode. You may or may not have had a major depressive episode. Because bipolar I varies from person to person, there are more-specific subcategories of diagnosis based on your particular signs and symptoms.
- **Bipolar II disorder.** You've had at least one major depressive episode and at least one hypomanic episode (but not a fully manic or mixed episode). With bipolar II, symptoms cause distress or difficulty in some area of your life — such as relationships or work. Bipolar II disorder also has subcategories based on your particular signs and symptoms.
- **Cyclothymic disorder.** You've had numerous hypomanic episodes and periods of depression — but you've never had a full manic episode, a major depressive episode or a mixed episode. For a diagnosis of cyclothymic disorder, symptoms last two years or more (one year in children and adolescents). During that time, symptoms never go away for more than two months. Symptoms cause significant distress or difficulty in some area of your life — such as in relationships or at work.

The DSM has very specific criteria for manic, hypomanic, major depressive and mixed episodes.

Criteria for a manic episode

A manic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood that lasts at least one week (or less than a week if hospitalization is necessary). During the period of disturbed mood, three or more of the following symptoms must be present (four if the mood is only irritable):

- Inflated self-esteem or grandiosity
- Decreased need for sleep (for example, you feel rested after only three hours of sleep)
- Unusual talkativeness
- Racing thoughts
- Distractibility
- Increased goal-directed activity (either socially, at work or school, or sexually)
- Doing things that have a high potential for painful consequences — for example, unrestrained buying sprees, sexual indiscretions or foolish business investments

To be considered a manic episode:

- The mood disturbance must be severe enough to cause noticeable difficulty at work, at school or in usual social activities or relationships; to require hospitalization to prevent harm to yourself or others; or to trigger a break from reality (psychosis).
- Symptoms do not meet the criteria for a mixed episode (see criteria for mixed episode below).
- Symptoms are not due to the direct effects of something else such as alcohol or drug use, taking a medication, or a having a medical condition such as hyperthyroidism.

Criteria for a hypomanic episode

A hypomanic episode is a distinct period of elevated, expansive or irritable mood that lasts at least four days, and is different from the usual nondepressed mood. During the period of disturbed mood, three or more of the following symptoms must be present (four if the mood is only irritable):

- Inflated self-esteem or grandiosity
- Decreased need for sleep (for example, you feel rested after only three hours of sleep)
- Unusual talkativeness
- Racing thoughts
- Distractibility
- Increased goal-directed activity (either socially, at work or school, or sexually)
- Doing things that have a high potential for painful consequences — for example, unrestrained buying sprees, sexual indiscretions or foolish business investments

To be considered a hypomanic episode:

- The mood disturbance must be severe enough to cause a noticeable and uncharacteristic change in functioning.
- The episode isn't severe enough to cause significant difficulty at work, at school or in usual social activities or relationships; to require hospitalization; or to trigger a break from reality (psychosis).
- Symptoms do not meet the criteria for a mixed episode (see criteria for mixed episode below).
- Symptoms are not due to the direct effects of something else such as alcohol or drug use, taking a medication, or a having a medical condition such as hyperthyroidism.

Criteria for a major depressive episode

To be diagnosed with a major depressive episode, you must have five (or more) of the following symptoms over a two-week period. At least one of the symptoms is either depressed mood or loss of interest or pleasure. Symptoms can be based on your own feelings or on the observations of someone else. They include:

- Depressed mood most of the day, nearly every day, such as feeling sad, empty or tearful (in children and adolescents, depressed mood can appear as constant irritability)
- Diminished interest or feeling no pleasure in all — or almost all — activities most of the day, nearly every day
- Significant weight loss when not dieting, weight gain, or decrease or increase in appetite nearly every day (in children, failure to gain weight as expected can be a sign of depression)
- Insomnia or increased desire to sleep nearly every day
- Either restlessness or slowed behavior that can be observed by others
- Fatigue or loss of energy nearly every day
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day
- Diminished ability to think or concentrate, or indecisiveness, nearly every day
- Recurrent thoughts of death or suicide, or a suicide attempt

To be considered a major depressive episode:

- Symptoms don't meet the criteria for a mixed episode (see criteria for mixed episode below).
- Symptoms must be severe enough to cause noticeable difficulty in day-to-day activities, such as work, school, social activities or relationships with others.
- Symptoms are not due to the direct effects of something else, such as drug abuse, taking a medication or a having a medical condition such as hyperthyroidism.
- Symptoms are not caused by grieving, such as after the loss of a loved one.

Criteria for mixed episode

- The criteria are met both for a manic episode and for a major depressive episode nearly every day during at least a one-week period.
- The mood disturbance must be severe enough to cause noticeable difficulty at work, at school, or in usual social activities or relationships; to require hospitalization to prevent harm to self or others; or to cause a break from reality (psychosis).
- Symptoms are not due to the direct effects of something else, such as drug abuse, taking a medication or a having a medical condition such as hyperthyroidism.

Diagnosis in children

The same official criteria used to diagnose bipolar disorder in adults are used to diagnose children and adolescents. However, bipolar symptoms in children and adolescents often have different patterns than they do in adults, and may not fit neatly into the categories used for diagnosis. While adults generally tend to have distinct periods of mania and depression, children and adolescents may have erratic, rapid changes in mood, behavior and energy levels.

It's often hard to tell whether these are normal ups and downs, the results of stress or trauma, or signs of a mental health problem other than bipolar disorder. To make it even more difficult, children who have bipolar disorder are frequently also diagnosed with other mental health conditions such as attention-deficit/hyperactivity disorder (ADHD) or behavior problems.

Although bipolar disorder can occur in young children, diagnosis in children preschool age or younger is especially difficult. The current criteria used for diagnosis have not been proved in young children, and a wide range of issues other than bipolar disorder can cause mood and behavior problems at this age.

Bipolar disorder requires lifelong treatment, even during periods when you feel better. Treatment is usually guided by a psychiatrist skilled in treating the condition. You may have a treatment team that also includes psychologists, social workers and psychiatric nurses. The primary treatments for bipolar disorder include medications; individual, group or family psychological counseling (psychotherapy); or education and support groups.

- **Hospitalization.** Your doctor may have you hospitalized if you are behaving dangerously, you feel suicidal or you become detached from reality (psychotic).
- **Initial treatment.** Often, you'll need to begin taking medications to balance your moods right away. Once your symptoms are under control, you'll work with your doctor to find the best long-term treatment.
- **Continued treatment.** Maintenance treatment is used to manage bipolar disorder on a long-term basis. People who skip maintenance treatment are at high risk of a relapse of symptoms or having minor mood changes turn into full-blown mania or depression.
- **Substance abuse treatment.** If you have problems with alcohol or drugs, you'll also need substance abuse treatment. Otherwise, it can be very difficult to manage bipolar disorder.

Medications

A number of medications are used to treat bipolar disorder. If one doesn't work well for you, there are a number of others to try. Your doctor may suggest combining medications for maximum effect. Medications for bipolar disorder include those that prevent the extreme highs and lows that can occur with bipolar disorder (mood stabilizers) and medications that help with depression or anxiety.

Medications for bipolar disorder include:

- **Lithium.** Lithium (Lithobid, others) is effective at stabilizing mood and preventing the extreme highs and lows of certain categories of bipolar disorder and has been used for many years. Periodic blood tests are required, since lithium can cause thyroid and kidney problems. Common side effects include restlessness, dry mouth and digestive issues.
- **Anticonvulsants.** These mood-stabilizing medications include valproic acid (Depakene, Stavzor), divalproex (Depakote) and lamotrigine (Lamictal). The medication asenapine (Saphris) may be helpful in treating mixed episodes. Depending on the medication you take, side effects can vary. Common side effects include weight gain, dizziness and drowsiness. Rarely, certain anticonvulsants cause more serious problems, such as skin rashes, blood disorders or liver problems.
- **Antipsychotics.** Certain antipsychotic medications, such as aripiprazole (Abilify), olanzapine (Zyprexa), risperidone (Risperdal) and quetiapine (Seroquel), may help people who don't benefit from anticonvulsants. The only antipsychotic that's specifically approved by the U.S. Food and Drug Administration (FDA) for treating bipolar disorder is quetiapine. However, doctors can still prescribe other medications for bipolar disorder. This is known as off-label use. Side effects depend on the medication, but can include weight gain, sleepiness, tremors, blurred vision and rapid heartbeat. Weight gain in children is a significant concern. Antipsychotic use may also affect memory and attention and cause involuntary facial or body movements.
- **Antidepressants.** Depending on your symptoms, your doctor may recommend you take an antidepressant. In some people with bipolar disorder, antidepressants can trigger manic episodes, but may be OK if taken along with a mood stabilizer. The most common antidepressant side effects include reduced sexual desire and problems reaching orgasm. Older antidepressants, which include tricyclics and MAO inhibitors, can cause a number of potentially dangerous side effects and require careful monitoring.
- **Symbyax.** This medication combines the antidepressant fluoxetine and the antipsychotic olanzapine. It works as a depression treatment and a mood stabilizer. Symbyax is approved by the FDA specifically for the treatment of bipolar disorder. Side effects can include weight gain, drowsiness and increased appetite. This medication may also cause sexual problems similar to those caused by antidepressants.
- **Benzodiazepines.** These anti-anxiety medications may help with anxiety and improve sleep. Examples include clonazepam (Klonopin), lorazepam (Ativan), diazepam (Valium), chlordiazepoxide (Librium) and alprazolam (Niravam, Xanax). Benzodiazepines are generally used for relieving anxiety only on a short-term basis. Side effects can include drowsiness, reduced muscle coordination, and problems with balance and memory.

Finding the right medication

Finding the right medication or medications for you will likely take some trial and error. This requires patience, as some medications need weeks to months to take full effect. Generally only one medication is changed at a time so your doctor can identify which medications work to relieve your symptoms with the least bothersome side effects. This can take months or longer, and medications may need to be adjusted as your symptoms change. Side effects improve as you find the right medications and doses that work for you, and your body adjusts to the medications.

Medications and pregnancy

A number of medications for bipolar disorder can be associated with birth defects.

- Use effective birth control (contraception) to prevent pregnancy. Discuss birth control options with your doctor, as birth control medications may lose effectiveness when taken along with certain bipolar disorder medications.
- If you plan to become pregnant, meet with your doctor to discuss your treatment options.
- Discuss breast-feeding with your doctor, as some bipolar medications can pass through breast milk to your infant.

Psychotherapy

Psychotherapy is another vital part of bipolar disorder treatment. Several types of therapy may be helpful. These include:

- **Cognitive behavioral therapy.** This is a common form of individual therapy for bipolar disorder. The focus of cognitive behavioral therapy is identifying unhealthy, negative beliefs and behaviors and replacing them with healthy, positive ones. It can help identify what triggers your bipolar episodes. You also learn effective strategies to manage stress and to cope with upsetting situations.
- **Psychoeducation.** Counseling to help you learn about bipolar disorder (psychoeducation) can help you and your loved ones understand bipolar disorder. Knowing what's going on can help you get the best support and treatment, and help you and your loved ones recognize warning signs of mood swings.
- **Family therapy.** Family therapy involves seeing a psychologist or other mental health provider along with your family members. Family therapy can help identify and reduce stress within your family. It can help your family learn how to communicate better, solve problems and resolve conflicts.
- **Group therapy.** Group therapy provides a forum to communicate with and learn from others in a similar situation. It may also help build better relationship skills.
- **Other therapies.** Other therapies that have been studied with some evidence of success include early identification and therapy for worsening symptoms (prodrome detection) and therapy to identify and resolve problems with your daily routine and interpersonal relationships (interpersonal and social rhythm therapy). Ask your doctor if any of these options may be appropriate for you.

Transcranial magnetic stimulation

This treatment applies rapid pulses of a magnetic field to the head. It's not clear exactly how this helps, but it appears to have an antidepressant effect. However, not everyone is helped by this therapy, and it's not yet clear who is a good candidate for this type of treatment. More research is needed. The most serious potential side effect is a seizure.

Electroconvulsive therapy (ECT)

Electroconvulsive therapy can be effective for people who have episodes of severe depression or feel suicidal or people who haven't seen improvements in their symptoms despite other treatment. With ECT, electrical currents are passed through your brain. Researchers don't fully understand how ECT works. But it's thought that the electric shock causes changes in brain chemistry that leads to improvements in your mood. ECT may be an option if you have mania or severe depression when you're pregnant and cannot take your regular medications. ECT can cause temporary memory loss and confusion.

Hospitalization

In some cases, people with bipolar disorder benefit from hospitalization. Getting psychiatric treatment at a hospital can help keep you calm and safe and stabilize your mood, whether you're having a manic episode or a deep depression. Partial hospitalization or day treatment programs also are options to consider. These programs provide the support and counseling you need while you get symptoms under control.

Treatment in children and adolescents

Children and adolescents with bipolar disorder are prescribed the same types of medications as those used in adults. However, there's little research on the safety and effectiveness of bipolar medications in children, so treatment decisions are based on adult research. Treatments are generally decided on a case-by-case basis, depending on exact symptoms, medication side effects and other factors. As with adults, ECT may be an option for adolescents with severe bipolar I symptoms or for whom medications don't work.

Most children diagnosed with bipolar disorder require counseling as part of initial treatment and to keep symptoms from returning. Psychotherapy — along with working with teachers and school counselors — can help children develop coping skills, address learning difficulties and resolve social problems. It can also help strengthen family bonds and communication. Psychotherapy may also be necessary to resolve substance abuse problems, common in older children with bipolar disorder.

You'll probably need to make lifestyle changes to stop cycles of behavior that worsen your bipolar disorder, and to make sure you get the support you need from people in your life. Here are some steps to take:

- **Quit drinking or using illegal drugs.** One of the biggest concerns with bipolar disorder is the negative consequences of risk-taking behavior and drug or alcohol abuse. Get help if you have trouble quitting on your own.
- **Steer clear of unhealthy relationships.** Surround yourself with people who are a positive influence and won't encourage unhealthy behavior or attitudes that can worsen your bipolar disorder.
- **Get regular exercise.** Moderate, regular exercise can help steady your mood. Working out releases brain chemicals that make you feel good (endorphins), can help you sleep and has a number of other benefits. Check with your doctor before starting any exercise program, especially if you're taking lithium to make sure exercise won't interfere with your medication.
- **Get plenty of sleep.** Sleeping enough is an important part of managing your mood. If you have trouble sleeping, talk to your doctor or mental health provider about what you can do.

Some alternative treatments may help, but there isn't much research on them. Most of the studies that do exist are on major depression, so it isn't clear how well most of these work for bipolar disorder.

- **Omega-3 fatty acids.** These oils may help improve brain function and depression associated with bipolar disorder. Bipolar disorder appears to be less common in areas of the world where people regularly eat fish rich in omega-3s. Omega-3s appear to have a number of health benefits, but more studies are needed to determine just how much they help with bipolar disorder.
- **Magnesium.** Several small studies have suggested that magnesium supplements may lessen mania and the rapid cycling of bipolar symptoms. More research is needed to confirm these findings.
- **St. John's wort.** This herb may be helpful with depression. However, it can also interact with antidepressants and other medications, and it has the potential to trigger mania in some people.
- **S-adenosyl-L-methionine (SAMe).** This amino acid supplement appears to help brain function related to depression. It isn't clear yet whether it's helpful in people with bipolar disorder. As with St. John's wort, SAMe can trigger mania in some people.

- **Herbal combinations.** Herbal remedies that combine a number of different herbs, such as those used in traditional Chinese medicine, haven't been well studied. Some appear to help, but the risks and benefits still aren't clear.
- **Acupuncture.** This ancient Chinese practice of inserting tiny needles into the skin may relieve depression, but more studies are needed to confirm its benefits. However, it won't hurt for you to try it — acupuncture is safe and can be done along with other bipolar disorder treatments.
- **Yoga.** Yoga may help ease depression and mood swings associated with bipolar disorder. It also has a number of other health benefits.
- **Massage therapy.** Massage may also help relieve anxiety and stress, which can worsen bipolar symptoms.

Although some alternative medicine treatments can be a good addition to your regular treatment, take some precautions first:

- **Don't stop taking your prescribed medications or skip therapy sessions.** Alternative medicine is not a substitute for regular medical care when it comes to treating bipolar disorder.
- **Be honest with your doctors and mental health providers.** Tell them exactly which complementary treatments you use or would like to try.
- **Be aware of potential dangers.** Just because it's natural doesn't mean it's safe. Before using alternative medicine, be sure you know the risks, including possible interactions with medications.

Coping with bipolar disorder can be challenging. Here are some things that can help:

- **Learn about bipolar disorder.** Education about your condition can empower you and motivate you to stick to your treatment plan. Likewise, help educate your family and friends about what you're going through.
- **Join a support group.** Support groups for people with bipolar disorder can help you connect to others facing similar challenges and share experiences.
- **Stay focused on your goals.** Recovery from bipolar disorder can take time. Stay motivated by keeping your recovery goals in mind and reminding yourself that you can work to repair damaged relationships and other problems caused by your mood swings.
- **Find healthy outlets.** Explore healthy ways to channel your energy, such as hobbies, exercise and recreational activities.
- **Learn ways to relax and manage stress.** Yoga, tai chi, meditation or other relaxation techniques can be helpful.

There's no sure way to prevent bipolar disorder. However, getting treatment at the earliest sign of a mental health disorder can help prevent bipolar disorder or other mental health conditions from worsening.

If you've been diagnosed with bipolar disorder, some strategies can help prevent minor episodes from becoming full-blown episodes of mania or depression:

- **Pay attention to warning signs.** Addressing symptoms early on can prevent episodes from getting worse. You and your caregivers may have identified a pattern to your bipolar episodes and what triggers them. Call your doctor if you feel you're falling into an episode of depression or mania. Involve family members or friends in watching for warning signs.
- **Avoid drugs and alcohol.** Even though you may initially feel better, using alcohol or street drugs makes your symptoms more likely to come back.
- **Take your medications exactly as directed.** Medications can have unwanted side effects, and you may feel unhappy about having a mental health condition that requires lifelong treatment. During periods when you feel better, you may be tempted to stop treatment. This can have immediate consequences — you may become very depressed, feel suicidal, or go into a manic or hypomanic episode. If you think you need to make a change, call your doctor.
- **Check first before taking other medications.** Call the doctor who's treating you for bipolar disorder before you take medications prescribed by another doctor. Sometimes other medications trigger episodes of bipolar disorder or may interfere with medications you're already taking to treat bipolar disorder.

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Jan. 18, 2012

Original article: http://www.mayoclinic.org/diseases-conditions/bipolar-disorder/basics/definition/con-20027544

DEF08

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Time Pt back 1257
Time Pt roomed 253

Visit Type: ☐ Urgent ☒ Routine ☐ Other

West Berkeley Family Practice

Progress Note

ER/Hospital since last visit Y (N)
Labs since last visit (Y) N
X-Ray since last visit Y (N)

Vitals
WT 202.2 HT
T 98.5
BP 130/82
P 93
RR
Tobacco: Y (N) Former

LMP
Birth Control Condoms
☐ HTN:

☐ Diabetes
RBG
Hgb A1c
done on
Brought Log? Y N

☐ Asthma O2
PF

Notes/CC:
- F/U medication
- Lab results

MA BP

Medications

Drug Allergies:

NKDA

☐ Pt brought meds
☐ Med list updated this visit

S 22yo ♀ here for flu anxiety. Was taking Depakote but stopped taking it a week after Rx'd. Has had anxiety for a long time but now is trying to deal w it. Occasional xanax helps panic attacks. Sees therapist, pays out of pocket

O: Gen: NAD, VSS.

A ① Anxiety
② STD test.

P Dx: GC/CT ☒ Handouts given
Educated about meditation, relaxation
Reduce triggers.
Explained dangers of benzos.
Consider SSRI to manage anxiety
LCSW referral for anxiety
RTC to FU re: anxiety @ PCP

FNP

☐ Tobacco advice given
☒ RTC/ER precautions given
Patient Education:
Return Visit: next week weeks/months As needed

Name HAGGERTY, MAKYL 137185
Medical Record DOB: 12/28/1989 510-599-6659
Date Z2--HealthPAC-MCE (3010008123611)
Date 953-TRAFEC/948-SA... 01/09/12

DEF010

Inmate Condensed Chart Report

Name: HAGGERTY, MAKYL A
MRN: 1924146
Agency#: 47230048 - UNV

DOB: 12/28/1989
Sex: M

PROBLEMS

Patient Problems	Category	Status	ICD9 Code	ICD10 Code
Anxiety disorder		Active	300.00	F41.9
Encounter for preventive health examination		Active	V70.0	Z00.00
Essential hypertension		Active	401.9	I10
Headache		Active	784.0	R51
Healthcare maintenance		Active	V70.0	Z00.00
Screening examination for pulmonary tuberculosis		Active	V74.1	Z11.1
History of ESSENTIAL HYPERTENSION		Resolved	401.9	I10

13-6D

Mental Health – Initial or Follow-Up Visit

Inmate/Resident Name: HAGGERTY, MAKYL A **Number** 47230048
DOB 12-28-89 **Facility:** NSDC **Date:** 03-20-13

SUBJECTIVE (Check all that apply.)

Unmarked box = not present. If additional writing space is needed to elaborate, use page 3 and reference numbers 1-4)

1) **Reason for this visit:** ☑ Initial ☐ Follow-up

2) **Referral source:**
☐ Sick Call ☑ Intake ☐ Medical staff ☐ Security ☐ Follow-up

3) **Chief complaint:**
☐ Depression ☐ Anxiety ☐ Psychosis ☐ Irritability
☐ Fear ☐ Anger ☐ Sleeplessness ☐ Decrease energy
☐ Thoughts of self-injury ☐ Drug withdrawal ☐ Change in appetite ☐ Poor concentration
☑ Other "I had gotten to a point where I was talking to myself, I scream".

4) **Please describe current signs and symptoms and/or responses to treatment:**
An inmate states that at times he would blurt out things that had happened in the past. In the past an one occasion had a breakdown when I cut my palm years ago. Inmate is a very vague historian. Other than per adjustment to incarceration did not elicit any clear Hx mania/psychosis.

OBJECTIVE (Check all that apply)

Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 5-12

5) **Please check all that apply**

Appearance:	☐ Neat	☑ Dishevelled	☐ Bizarre	☐ Tense	☐ Poised	☑ Appropriate
Behavior:	☑ Calm	☐ Agitated	☐ Paranoid	☐ Restless	☑ Cooperative	
Mood:	☐ Depressed	☑ Anxious	☐ Labile	☐ Euthymic	☐ Frightened	
Affect:	☐ Blunted	☑ Within Normal Limits		☐ Flat	☐ Constricted	
Speech:	☐ Rapid	☐ Pressured	☐ Mumbled	☐ Soft	☑ Normal	
Perception:	☐ Hallucinations	☐ Illusions	☑ No Abnormalities			
Thought process:	☑ Organized	☐ Racing	☐ Loose Associations		☐ Flight of Ideas	
Thought content:	☐ Suicidal	☐ Homicidal	☐ Delusions	☐ Paranoia	☐ Phobias	more elicited

6) **Oriented to person, place, and time:** ☑ Yes ☐ No Specify _____

7) **Concentration intact:** ☑ Yes ☐ No **Memory intact:** ☑ Yes ☐ No

8) **Abstract thinking intact:** ☑ Yes ☐ No **Insight and judgment intact:** ☑ Yes ☐ No

9) **Reliable history and information:** Record ☑ Yes ☐ No **From patient:** ☑ Yes ☐ No

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DEF012

MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

OBJECTIVE *(continued)* (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 4-11

10) For new patients check all that apply: no hx. suicidal behavior.

- ☒ Prior mental health treatment
- ☐ Recent suicidal/homicidal ideations
- ☐ History of psychiatric hospitalization
- ☐ Current treatment with psychotropics
- ☐ Prior suicide attempt

Prozac >1 year ago.

11) Comments regarding result of AIMS assessment (if receiving antipsychotics / neuroleptics / phenothiazines):

12) Current Medications: ☐ Reviewed Compliant with **current medication regimen and/or treatment?** ☐ No ☐Yes

** It is unacceptable to document " See MAR." Medication name, Dosage and Frequency must be completed

Medication	Dosage	Frequency

Have medications or dosages changed over the past 8 **weeks?** ☐ No ☐Yes, Specify _____

Medication Allergies? ☐ No ☐Yes, List _____

ASSESSMENT (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference number 13

13) Diagnosis:

AXIS I 309 + 312.
AXIS II Hx ASPD
AXIS III none
AXIS IV Incarceration
AXIS V 59.

PLAN *(action taken this visit)*
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 14-17)

14) Plan: Include new meds prescribed and/or dosage changes

~~Haldol 5mg~~ - prozac 20mg po QAM.
Explained relaxation exercises.

*** Female offenders must have a pregnancy test prior to initiation of psychotropic medications

15) Follow-up:

- 12 weeks or RTC earlier if need be.

16) Education:

Counseled on Medication Effects & S/E ☒ Yes ☐ No
Counseled on Signs of Toxicity ☒ Yes ☐ No
Counseled on Medication Compliance ☒ Yes ☐ No
Informed Consent for Medications ☒ Yes ☐ No

17) Return visit: ☐ 2 weeks ☐ 1 month ☒ 3 months ☐ other _____
(order must be written for next scheduled visit, to include laboratory testing, diet, medications, or other therapies)

Name: HAGGERTY, MAKYL A **Number** 47230048

Signature: ~~[illegible]~~ Brennan ☒ LIP ☐ QMHP **Date:** 03-20-13

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

Please use this page to comment on findings from previous pages

Subjective *(continued using reference numbers 1-4)*

N/A

Objective *(continued using reference numbers 5-12)*

N/A

Assessment *(continued using reference number 13)*

N/A

Plan *(action taken this visit – continued using reference numbers 14-17)*

N/A

Name: HAGGERTY, MAKYL A **Number** 47230048

Signature: [signature] ☑ LIP ☐ QMHP **Date:** 03-20-13

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13-6D

Mental Health – Initial or Follow-Up Visit

Inmate/Resident Name: HAGGERTY, MAKYL A **Number:** 47230048
DOB: 12-28-89 **Facility:** NSDC **Date:** 04/24/13

SUBJECTIVE (Check all that apply.)

Unmarked box = not present. If additional writing space is needed to elaborate, use page 3 and reference numbers 1-4)

1) Reason for this visit: ☐ Initial ☑ Follow-up

2) Referral source:

☐ Sick Call ☐ Intake ☐ Medical staff ☐ Security ☐ Follow-up

3) Chief complaint:

☐ Depression ☐ Anxiety ☐ Psychosis ☐ Irritability
☐ Fear ☐ Anger ☐ Sleeplessness ☐ Decrease energy
☐ Thoughts of self-injury ☐ Drug withdrawal ☐ Change in appetite ☐ Poor concentration
☐ Other

"I was feeling numb [illegible] the medication & that was not ok".

4) Please describe current signs and symptoms and/or responses to treatment:

reports he did not feel any emotion on [illegible] & hence wanted to discontinue. He however still [illegible] periods where he experiences ↑ anxiety. Normally tries to control this with exercise. Currently denies any hopeless or helpless feelings. Not S/H on evaluation.

OBJECTIVE (Check all that apply)

Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 5-12

5) Please check all that apply

Appearance:	☑ Neat	☐ Disheveled	☐ Bizarre	☐ Tense	☐ Poised	☑ Appropriate
Behavior:	☑ Calm	☐ Agitated	☐ Paranoid	☐ Restless	☑ Cooperative	
Mood:	☐ Depressed	☐ Anxious	☐ Labile	☑ Euthymic	☐ Frightened	
Affect:	☐ Blunted	☑ Within Normal Limits		☐ Flat	☐ Constricted	
Speech:	☐ Rapid	☐ Pressured	☐ Mumbled	☐ Soft	☑ Normal	
Perception:	☐ Hallucinations	☐ Illusions	☑ No Abnormalities			
Thought process:	☑ Organized	☐ Racing	☐ Loose Associations		☐ Flight of Ideas	
Thought content:	☐ ~~Suicidal~~	☐ ~~Homicidal~~	☐ ~~Delusions~~	☐ ~~Paranoia~~	☐ ~~Phobias~~	→ none elicited.

6) Oriented to person, place, and time: ☑ Yes ☐ No Specify

7) Concentration intact: ☑ Yes ☐ No **Memory intact:** ☑ Yes ☐ No

8) Abstract thinking intact: ☑ Yes ☐ No **Insight and judgment intact:** ☑ Yes ☐ No

9) Reliable history and information: Record ☑ Yes ☐ No **From patient:** ☑ Yes ☐ No

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DEF015

MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

OBJECTIVE *(continued)* (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 4-11

10) For new patients check all that apply:

- ☑ Prior mental health treatment
- ☐ History of psychiatric hospitalization
- ☐ Prior suicide attempt
- ☐ Recent suicidal/homicidal ideations
- ☐ Current treatment with psychotropics

11) Comments regarding result of AIMS assessment (if receiving antipsychotics / neuroleptics / phenothiazines):

_____

_____

12) Current Medications: ☐ Reviewed **Compliant with current medication regimen and/or treatment?** ☐ No ☐Yes

** It is unacceptable to document " See MAR." Medication name, Dosage and Frequency must be completed

Medication	Dosage	Frequency

Have medications or dosages changed over the past 8 weeks? ☐ No ☐Yes, Specify _____

Medication Allergies? ☐ No ☐Yes, List _____

ASSESSMENT (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference number 13

13) Diagnosis:

AXIS I 309, 312.
AXIS II No ASPD
AXIS III none
AXIS IV Incarceration.
AXIS V 60.

PLAN *(action taken this visit)*
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 14-17)

14) Plan: Include new meds prescribed and/or dosage changes

- Vistaril 50 mg po PRN BID.
~~discontinued~~.

*** Female offenders must have a pregnancy test prior to initiation of psychotropic medications

15) Follow-up: follow up 12 weeks, or RTC earlier if need be

16) Education:

Counseled on Medication Effects & S/E ☑ Yes ☐ No
Counseled on Signs of Toxicity ☑ Yes ☐ No
Counseled on Medication Compliance ☑ Yes ☐ No
Informed Consent for Medications ☑ Yes ☐ No

17) Return visit: ☐ 2 weeks ☐ 1 month ☑ 3 months ☐ other _____
(order must be written for next scheduled visit, to include laboratory testing, diet, medications, or other therapies)

Name: HAGGERTY, MAKYL A **Number:** 47230048

Signature: [signature] ☑ LIP ☐ QMHP **Date:** 04/24/13

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MENTAL HEALTH -- INITIAL OR FOLLOW-UP VISIT **13-6D**

Please use this page to comment on findings from previous pages

Subjective *(continued using reference numbers 1-4)*

N/A

Objective *(continued using reference numbers 5-12)*

N/A

Assessment *(continued using reference number 13)*

N/A

Plan *(action taken this visit – continued using reference numbers 14-17)*

N/A

Name: HAGGERTY, MAKYL A **Number:** 47230048

Signature: Brenham. ☑LIP ☐ QMHP **Date:** 04/2413

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13-6D

Mental Health – Initial or Follow-Up Visit F2 5B

Inmate/Resident Name HAGGERTY, MARYL A. Number 4723004B DOB 12-28-89

Facility: NSDC _____ Date / Time: 7/17/13 ___:___ am pm

SUBJECTIVE (Check all that apply.)
Unmarked box = not present. If additional writing space is needed to elaborate, use page 3 and reference numbers 1-4)

1) **Reason for this visit:** ☐ Initial ☑ Follow-up

2) **Referral source:**
☐ Sick Call ☐ Intake ☐ Medical staff ☐ Security ☑ Follow-up

3) **Chief complaint:**
☐ Depression ☐ Anxiety ☐ Psychosis ☐ Irritability
☐ Fear ☐ Anger ☐ Sleeplessness ☐ Decrease energy
☐ Thoughts of self-injury ☐ Drug withdrawal ☐ Change in appetite ☐ Poor concentration
☑ Other _____

Says doing well

4) **Please describe current signs and symptoms and/or responses to treatment:**
Reports doing well now that he is out of CA & also as he is now working as a porter. Denies any problems, requests to change meds to PRN basis.

OBJECTIVE (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 5-12

5) **Please check all that apply**

Appearance:	☑ Neat	☐ Disheveled	☐ Bizarre	☐ Tense	☐ Poised	☑ Appropriate
Behavior:	☑ Calm	☐ Agitated	☐ Paranoid	☐ Restless	☑ Cooperative	
Mood:	☐ Depressed	☐ Anxious	☐ Labile	☑ Euthymic	☐ Frightened	
Affect:	☐ Blunted	☑ Within Normal Limits		☐ Flat	☐ Constricted	
Speech:	☐ Rapid	☐ Pressured	☐ Mumbled	☐ Soft	☑ Normal	
Perception:	☐ Hallucinations	☐ Illusions	☑ No Abnormalities			
Thought process:	☑ Organized	☐ Racing	☐ Loose Associations		☐ Flight of Ideas	
Thought content:	☐ Suicidal	☐ Homicidal	☐ Delusions	☐ Paranoia	☐ Phobias → none elicited	

6) **Oriented to person, place, and time:** ☑ Yes ☐ No Specify _____

7) **Concentration intact:** ☑ Yes ☐ No **Memory intact:** ☑ Yes ☐ No

8) **Abstract thinking intact:** ☑ Yes ☐ No **Insight and judgment intact:** ☑ Yes ☐ No

9) **Reliable history and information:** **Record** ☑ Yes ☐ No **From patient:** ☑ Yes ☐ No

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT 13-6D

OBJECTIVE *(continued)* (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 4-11

10) For new patients check all that apply:

- ☐ Prior mental health treatment
- ☐ History of psychiatric hospitalization
- ☐ Prior suicide attempt
- ☐ Recent suicidal/homicidal ideations
- ☑ Current treatment with psychotropics

11) Comments regarding result of AIMS assessment (if receiving antipsychotics / neuroleptics / phenothiazines):

_____

_____

12) Current Medications: ☐ Reviewed **Compliant with current medication regimen and/or treatment?** ☐ No ☐Yes

** It is unacceptable to document " See MAR." Medication name, Dosage and Frequency must be completed

Medication	Dosage	Frequency

Have medications or disages changed over the past 8 weeks? ☐ No ☐Yes, Specify _____

Medication Allergies? ☐ No ☐Yes, List _____

ASSESSMENT (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference number 13

13) Diagnosis:

AXIS I 309 mixed, 312 in remission

AXIS II Rule Out ASPD

AXIS III none

AXIS IV Incarceration

AXIS V 65

PLAN *(action taken this visit)*
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 14-17)

14) Plan: Include new meds prescribed and/or dosage changes

Change listed to PRN dosing.

*** Female offenders must have a pregnancy test prior to initiation of psychotropic medications

15) Follow-up: 2 weeks or RC earlier if needed

16) Education:

Counseled on Medication Effects & S/E ☑ Yes ☐ No
Counseled on Signs of Toxicity ☑ Yes ☐ No
Counseled on Medication Compliance ☑ Yes ☐ No
Informed Consent for Medications ☑ Yes ☐ No

17) Return visit: ☐ 2 weeks ☐ 1 month ☑ 3 months ☐ other _____

(order must be written for next scheduled visit, to include laboratory testing, diet, medications, or other therapies)

Name: HAGGERTY, MARYL A. **Inmate/Resident #** 47230048

Signature: _____ Dr. Suresh Bhushan ☒ LIP ☐ QMHP **Date:** 7-17-13

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

Please use this page to comment on findings from previous pages

Subjective *(continued using reference numbers 1-4)*

N/A

Objective *(continued using reference numbers 5-12)*

N/A

Assessment *(continued using reference number 13)*

N/A

Plan *(action taken this visit – continued using reference numbers 14-17)*

N/A

Name: HAGGERTY, MARYL A. **Inmate/Resident #** 47230048

Signature: _____ Dr. Suresh Bhushan ☒ LIP ☐ QMHP **Date:** 7-17-13

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13-6D

Mental Health – Initial or Follow-Up Visit F3 13B

Inmate/Resident Name: HAGGERTY, MAKYL **Number:** 47230048

DOB: 12-28-89 **Facility:** NSDC **Date:** 10-16-13

SUBJECTIVE (Check all that apply.)

Unmarked box = not present. If additional writing space is needed to elaborate, use page 3 and reference numbers 1-4)

1) **Reason for this visit:** ☐ Initial ☑ Follow-up

2) **Referral source:**
☐ Sick Call ☐ Intake ☐ Medical staff ☐ Security ☑ Follow-up

3) **Chief complaint:**

☐ Depression	☑ Anxiety	☐ Psychosis	☐ Irritability
☐ Fear	☐ Anger	☐ Sleeplessness	☐ Decrease energy
☐ Thoughts of self-injury	☐ Drug withdrawal	☐ Change in appetite	☐ Poor concentration

☐ Other was screaming [illegible] to [illegible]

→ Mood has been [illegible]. Pt is currently [illegible] @ facility.

4) **Please describe current signs and symptoms and/or responses to treatment:**

F/u from Dr. [illegible] [illegible] [illegible] [illegible] [illegible] anxiety [illegible] [illegible] [illegible] [illegible]

OBJECTIVE (Check all that apply)

Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 5-12

5) **Please check all that apply**

Appearance:	☑ Neat	☐ Disheveled	☐ Bizarre	☐ Tense	☐ Poised	☐ Appropriate
Behavior:	☑ Calm	☐ Agitated	☐ Paranoid	☐ Restless	☐ Cooperative	
Mood:	☐ Depressed	☐ Anxious	☐ Labile	☐ Euthymic	☐ Frightened	Good
Affect:	☐ Blunted	☐ Within Normal Limits		☐ Flat	☐ Constricted	Full
Speech:	☐ Rapid	☐ Pressured	☐ Mumbled	☐ Soft	☑ Normal	
Perception:	☐ Hallucinations (ø)	☐ Illusions	☐ No Abnormalities			
Thought process:	☐ Organized	☐ Racing	☐ Loose Associations		☐ Flight of Ideas	
Thought content:	☐ Suicidal	☐ Homicidal (ø)	☐ Delusions	☐ Paranoia (ø)	☐ Phobias	

6) **Oriented to person, place, and time:** ☑ Yes ☐ No Specify ______

7) **Concentration intact:** ☑ Yes ☐ No **Memory intact:** ☑ Yes ☐ No

8) **Abstract thinking intact:** ☑ Yes ☐ No **Insight and judgment intact:** ☑ Yes ☐ No

9) **Reliable history and information:** Record ☑ Yes ☐ No **From patient:** ☑ Yes ☐ No

 12/5/11

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT 13-6D

OBJECTIVE *(continued)* (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 4-11

10) For new patients check all that apply:

- ☐ Prior mental health treatment
- ☐ Recent suicidal/homicidal ideations
- ☐ History of psychiatric hospitalization
- ☐ Current treatment with psychotropics
- ☐ Prior suicide attempt

11) Comments regarding result of AIMS assessment (if receiving antipsychotics / neuroleptics / phenothiazines):

12) Current Medications: ☐ Reviewed **Compliant with current medication regimen and/or treatment?** ☐ No ☐ Yes

** It is unacceptable to document " See MAR." Medication name, Dosage and Frequency must be completed

Medication	Dosage	Frequency
Hydroxyzine		PRN

Have medications or dosages changed over the past 8 weeks? ☐ No ☐ Yes, Specify

Medication Allergies? ☐ No ☐ Yes, List

ASSESSMENT (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference number 13

13) Diagnosis: Bipolar D/O NOS

AXIS I Anxiety D/O NOS / Alcohol & THC Dep.

AXIS II Def

AXIS III HTN / BSW LE

AXIS IV

AXIS V 55

PLAN *(action taken this visit)*
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 14-17)

14) Plan: Include new meds prescribed and/or dosage changes
1) [illegible] re THC Abstinence Counseling
2) Δ Vistaril to Buspar 15 BID PRN Anxiety

*** Female offenders must have a pregnancy test prior to initiation of psychotropic medications

15) Follow-up: 4 wks

16) Education:

Counseled on Medication Effects & S/E ☑ Yes ☐ No Counseled on Medication Compliance ☐ Yes ☐ No
Counseled on Signs of Toxicity ☑ Yes ☐ No Informed Consent for Medications ☐ Yes ☐ No

17) Return visit: ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ other 11-13-13
(order must be written for next scheduled visit, to include laboratory testing, diet, medications, or other therapies)

Name: HAGGERTY, MARY **Inmate/Resident #** 47230048

Signature: [signature] Daniel Sussman, MD ☒ LIP ☐ QMHP **Date:** 10-16-13

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

Please use this page to comment on findings from previous pages

Subjective *(continued using reference numbers 1-4)*

N/A

Objective *(continued using reference numbers 5-12)*

N/A

Assessment *(continued using reference number 13)*

N/A

Plan *(action taken this visit – continued using reference numbers 14-17)*

N/A

Name: HAGGERTY, MARYL **Inmate/Resident #** 47230048

Signature: Daniel Sussman, MD ☒ LIP ☐ QMHP **Date:** 10-16-13

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13-6D

Mental Health – Initial or Follow-Up Visit F3 13B

Inmate/Resident Name: HAGGERTY, MARYL **Number:** 47230048

DOB: 12-28-89 **Facility:** NSDC **Date:** 11-13-13

SUBJECTIVE (Check all that apply.)

Unmarked box = not present. If additional writing space is needed to elaborate, use page 3 and reference numbers 1-4)

1) **Reason for this visit:** ☐ Initial ☒ Follow-up

2) **Referral source:**

☐ Sick Call ☐ Intake ☐ Medical staff ☐ Security ☒ Follow-up 4 wks

3) **Chief complaint:**

☐ Depression	☐ Anxiety	☐ Psychosis	☐ Irritability
☐ Fear	☐ Anger	☐ Sleeplessness	☐ Decrease energy
☐ Thoughts of self-injury	☐ Drug withdrawal	☐ Change in appetite	☐ Poor concentration
☐ Other			

4) **Please describe current signs and symptoms and/or responses to treatment:**

Saw Carter 10/16

Never took Suspen.

Recent anxiety - moderate - wants to medicate instead

OBJECTIVE (Check all that apply)

Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 5-12

5) **Please check all that apply**

Appearance:	☒ Neat	☐ Disheveled	☐ Bizarre	☐ Tense	☐ Poised	☐ Appropriate
Behavior:	☒ Calm	☐ Agitated	☐ Paranoid	☐ Restless	☐ Cooperative	
Mood:	☐ Depressed	☐ Anxious	☐ Labile	☒ Euthymic	☐ Frightened	
Affect:	☐ Blunted	☒ Within Normal Limits		☐ Flat	☐ Constricted	
Speech:	☐ Rapid	☐ Pressured	☐ Mumbled	☐ Soft	☒ Normal "good"	
Perception:	☐ Hallucinations	☐ Illusions	☒ No Abnormalities			
Thought process:	☒ Organized	☐ Racing	☐ Loose Associations		☐ Flight of Ideas	
Thought content:	☐ Suicidal	☐ Homicidal	☐ Delusions	☐ Paranoia	☐ Phobias	(occas AH

6) **Oriented to person, place, and time:** ☒ Yes ☐ No Specify _____

7) **Concentration intact:** ☒ Yes ☐ No **Memory intact:** ☒ Yes ☐ No

8) **Abstract thinking intact:** ☒ Yes ☐ No **Insight and judgment intact:** ☒ Yes ☐ No

9) **Reliable history and information:** **Record** ☒ Yes ☐ No **From patient:** ☒ Yes ☐ No

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT 13-6D

OBJECTIVE *(continued)* (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 4-11

10) For new patients check all that apply:
- ☐ Prior mental health treatment
- ☐ Recent suicidal/homicidal ideations
- ☐ History of psychiatric hospitalization
- ☐ Current treatment with psychotropics
- ☐ Prior suicide attempt

11) Comments regarding result of AIMS assessment (if receiving antipsychotics / neuroleptics / phenothiazines):

12) Current Medications: ☐ Reviewed **Compliant with current medication regimen and/or treatment?** ☐ No ☐ Yes
** It is unacceptable to document " See MAR." Medication name, Dosage and Frequency must be completed

Medication	Dosage	Frequency
Buspar	15mg	BID

Have medications or dosages changed over the past 8 weeks? ☐ No ☐ Yes, Specify

Medication Allergies? ☒ No ☐ Yes, List

ASSESSMENT (Check all that apply)
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference number 13

13) Diagnosis:
AXIS I Bipolar D/O NOS / Alcohol & Stimulant Dep r/o S.P.D
AXIS II Def
AXIS III
AXIS IV
AXIS V

PLAN *(action taken this visit)*
Unmarked box =not present. If additional writing space is needed to elaborate use page 3 and reference numbers 14-17)

14) Plan: Include new meds prescribed and/or dosage changes
D/C Buspar.

*** Female offenders must have a pregnancy test prior to initiation of psychotropic medications

15) Follow-up: Supp Tx - ? amenable to Rx Sx w-(D, presents well

16) Education:
Counseled on Medication Effects & S/E ☒ Yes ☐ No Counseled on Medication Compliance ☒ Yes ☐ No
Counseled on Signs of Toxicity ☒ Yes ☐ No Informed Consent for Medications ☒ Yes ☐ No

17) Return visit: ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ other Ø NA
(order must be written for next scheduled visit, to include laboratory testing, diet, medications, or other therapies)

Name: HAGGERTY, MARYL **Inmate/Resident #** 47230048

Signature: [signature] Daniel Sussman, MD ☒ LIP ☐ QMHP **Date:** 11-13-13

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MENTAL HEALTH – INITIAL OR FOLLOW-UP VISIT **13-6D**

Please use this page to comment on findings from previous pages

Subjective *(continued using reference numbers 1-4)*

N/A

Objective *(continued using reference numbers 5-12)*

N/A

Assessment *(continued using reference number 13)*

N/A

Plan *(action taken this visit – continued using reference numbers 14-17)*

N/A

Name: HAGGERTY, MARYL **Inmate/Resident #** 47230048

Signature: Daniel Sussman, MD ☒ LIP ☐ QMHP **Date:** 11-13-13

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Name: HAGGERTY, MAKYL A
MRN: 1924146
Agency#: 47230048 - UNV
DOB: 12/28/1989
Sex: M

All Medications

Medications	Order Date	Provider	Stop Date	Status
Acetaminophen 325 MG Oral Tablet TAKE 2 TABLET TWICE DAILY PRN PO	04/30/2013	Saavedra, Rubin M.D.	05/04/2013	Complete
AmLODIPine Besylate 5 MG Oral Tablet TAKE 1 TABLET BEDTIME P.O.	08/20/2013	Hanf, Ted D.O.	11/01/2013	Discontinued
BusPIRone HCl - 15 MG Oral Tablet TAKE 1 TABLET TWICE DAILY PRN anxiety	10/16/2013	Sussman, Daniel	11/13/2013	Discontinued
Cephalexin 500 MG Oral Capsule TAKE 2 CAPSULE TWICE DAILY Fulkerson, Ashley ~ 05/31/2013 8:23 PM Formulary Override Reason: No Formulary Equivalent Exists	05/31/2013	Hanf, Ted D.O.	06/13/2013	Complete
Chlorpheniramine Maleate 4 MG Oral Tablet TAKE 1 TABLET TWICE DAILY po	04/08/2013	Saavedra, Rubin M.D.	04/13/2013	Complete
Cyclobenzaprine HCl - 10 MG Oral Tablet TAKE 1 TABLET TWICE DAILY PRN	09/24/2013	Hanf, Ted D.O.	10/10/2013	Complete
Excedrin Migraine 250-250-65 MG Oral Tablet TAKE 2 TABLET OTHER PRN po	05/12/2013	Kabatay, Dulce APN	05/12/2013	Discontinued
Excedrin Migraine 250-250-65 MG Oral Tablet TAKE 2 TABLET TWICE DAILY PRN PO	05/12/2013	Kabatay, Dulce APN	05/27/2013	Complete
Excedrin Migraine 250-250-65 MG Oral Tablet TAKE 2 TABLET TWICE DAILY PRN p.o	05/31/2013	Hanf, Ted D.O.	07/30/2013	Complete
Excedrin Migraine 250-250-65 MG Oral Tablet TAKE 2 TABLET TWICE DAILY PRN p.o	08/20/2013	Hanf, Ted D.O.	09/23/2013	Complete
Fiber 625 MG Oral Tablet TAKE 3 TABLET DAILY	11/04/2013	Hanf, Ted D.O.	11/11/2013	Complete
Flulaval Intramuscular Injectable INJECT 0.5 ML ONCE	11/08/2013	Hanf, Ted D.O.	11/09/2013	Entered in Error
FLUoxetine HCl - 20 MG Oral Capsule TAKE 1 CAPSULE DAILY.	03/20/2013	Bhushan, Suresh M.D.	04/17/2013	Discontinued
HydrOXYzine HCl - 50 MG Oral Tablet TAKE 1 TABLET TWICE DAILY PRN	07/17/2013	Bhushan, Suresh M.D.	08/22/2013	Entered in Error
Ibuprofen 200 MG Oral Tablet TAKE 2 TABLET TWICE DAILY P.O	08/04/2013	Hanf, Ted D.O.	08/08/2013	Complete
Lisinopril 20 MG Oral Tablet TAKE 1 TABLET DAILY PO	03/20/2013	Saavedra, Rubin M.D.	05/31/2013	Discontinued
Meloxicam 7.5 MG Oral Tablet TAKE 1 TABLET TWICE DAILY PRN po- OK TO KOP	07/16/2013	Hanf, Ted D.O.	10/16/2013	Complete
Meloxicam 7.5 MG Oral Tablet TAKE 1 TABLET TWICE DAILY	01/13/2014	Hanf, Ted D.O.	04/05/2014	Complete
Methocarbamol 750 MG Oral Tablet TAKE 1 TABLET TWICE DAILY AS NEEDED.	05/31/2013	Hanf, Ted D.O.	07/04/2013	Complete

Amlodipine

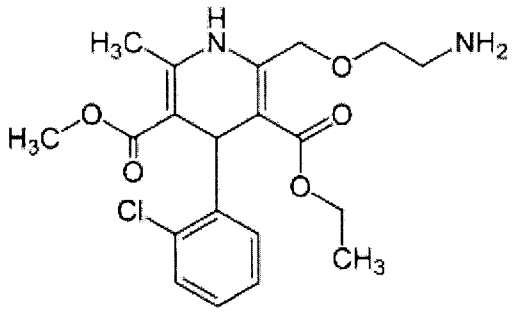
From Wikipedia, the free encyclopedia

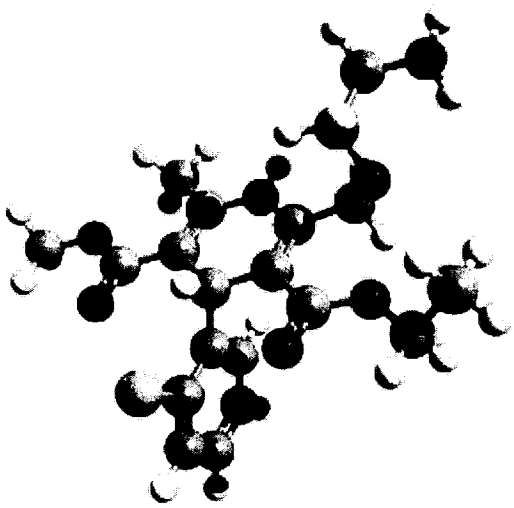
Amlodipine (**Norvasc** (Pfizer) and generics) (as besylate, mesylate or maleate) is a long-acting dihydropyridine-type (DHP) calcium channel blocker used to lower blood pressure and to treat anginal chest pain. Like other calcium channel blockers, amlodipine lowers blood pressure by relaxing arterial smooth muscles, which decreases total peripheral resistance and therefore reduces blood pressure. In angina, amlodipine increases blood flow to the heart muscle (although DHP-class calcium channel blockers are more selective for arteries than the muscular tissue of the heart (myocardium), as the calcium ion channels of the heart are not of the dihydropyridine-type).

It is on the World Health Organization's List of Essential Medicines, a list of the most important medication needed in a basic health system.[1]

Contents

Amlodipine





Systematic (IUPAC) name

(*RS*)-3-ethyl 5-methyl 2-[(2-aminoethoxy)methyl]-4-(2-chlorophenyl)-6-methyl-1,4-dihydropyridine-3,5-dicarboxylate

Clinical data

AHFS/Drugs.com	monograph
MedlinePlus	a692044
Licence data	US FDA:link
Pregnancy cat.	C (AU) C (US)
Legal status	POM (UK) ℞-only (US)
Routes	Oral (tablets)

Pharmacokinetic data

Bioavailability	64 to 90%
Metabolism	Hepatic
Half-life	30 to 50 hours
Excretion	Renal

Medical uses

Amlodipine is used in the management of hypertension [2] and coronary artery disease.[3]

Contraindications

- Breast feeding
- Cardiogenic shock
- Unstable angina
- Systolic and diastolic blood pressure below 90/60 mmHg
- Aortic stenosis: Amlodipine causes vasodilation, which can result in reduced cardiac output in patients with severe aortic stenosis.

Identifiers	
CAS number	88150-42-9 ✓
ATC code	C08CA01
PubChem	CID 2162
DrugBank	DB00381
ChemSpider	2077 ✓
UNII	1J444QC288 ✓
KEGG	D07450 ✓
ChEBI	CHEBI:2668 ✓
ChEMBL	CHEMBL1491 ✓
Chemical data	
Formula	$C_{20}H_{25}ClN_2O_5$
Mol. mass	408.879 g/mol
SMILES	
InChI	

✓ **(what is this?) (verify)**

Adverse effects

Adverse side effects of the use of amlodipine may include:[4]

- Common: peripheral edema in 8.3% of users, fatigue in 4.5% of users[5] dizziness; palpitations; stomach-pain, headache, dyspepsia, somnolence(sleepiness) and/or nausea in greater than 1%.
- Uncommon: blood disorders, development of breasts in men (gynecomastia), impotence, depression, insomnia, tachycardia, or gingival enlargement - in one in 1,000 users
- Rarely: erratic behavior, hepatitis, jaundice - in one in 10,000 users
- Very rarely: hyperglycemia, tremor, Stevens–Johnson syndrome - in one in 100,000 users

The acute oral toxicity (LD50) of amlodipine in mice is 37 mg/kg.[6]

Cautions

- Hepatic impairment
- Pregnancy

Interactions

- In patients with severe coronary artery disease, amlodipine can increase the frequency and severity of angina or actually cause a heart attack on rare occasions.

Buspirone

From Wikipedia, the free encyclopedia

Buspirone (pronounced /ˈbjuːspɪroʊn/ ***BEW-spi-rohn***), trade name **Buspar** (pronounced ***BYOO-spar***), is an anxiolytic psychotropic drug[2] of the azapirone chemical class. It is primarily used to treat generalized anxiety disorder (GAD). Unlike most drugs predominately used to treat anxiety, buspirone's pharmacology is not related to benzodiazepines or barbiturates, and so does not carry the risk of physical dependence and withdrawal symptoms those drug classes are known for when discontinued.

Buspirone was first identified by a team at Mead Johnson[3] in 1972, but wasn't patented until 1975.[4]

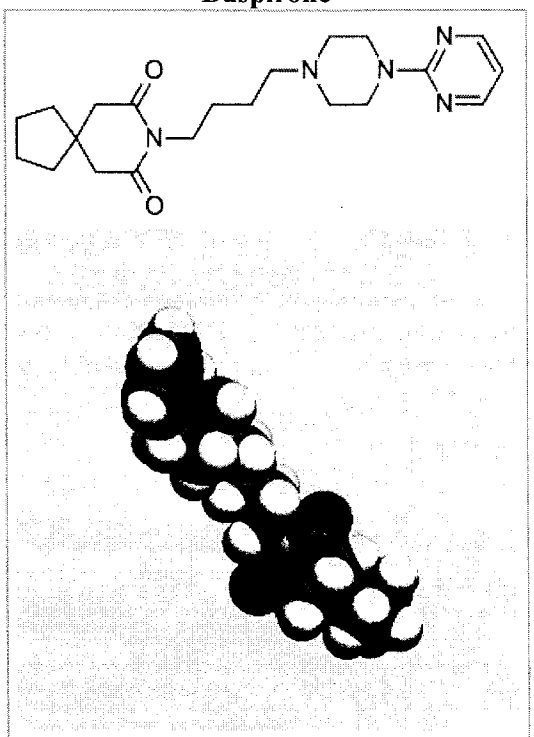
In 1986, Bristol-Myers Squibb (BMS) gained Food and Drug Administration (FDA) approval for buspirone in the treatment of GAD. The BMS patent placed on buspirone expired in 2001 and buspirone is now available as a generic drug.

Contents

Medical uses

Buspirone is approved, in the US, by the FDA for the treatment of anxiety disorders and the short-term relief of the symptoms of anxiety.[5] Likewise in Australia buspirone is licensed for the treatment of anxiety disorders.[6][7] In the UK buspirone is indicated only for the short-term treatment of anxiety.[8][9]

Buspirone



Systematic (IUPAC) name

8-[4-(4-pyrimidin-2-ylpiperazin-1-yl)butyl]-8-azaspiro[4.5]decane-7,9-dione

Clinical data	
Trade names	Buspar
AHFS/Drugs.com	monograph
MedlinePlus	a688005
Pregnancy cat.	B1 (AU) B (US)
Legal status	Prescription Only (S4) (AU) ℞-only (CA) POM (UK) ℞-only (US)
Routes	Oral
Pharmacokinetic data	
Bioavailability	~4%[1]
Protein binding	86-95%[1]
Metabolism	Hepatic mostly via CYP3A4[1]
Half-life	2-3 hours[1]
Excretion	Urine (29-63%), Faeces (18-38%)[1]
Identifiers	
CAS number	36505-84-7
ATC code	N05BE01

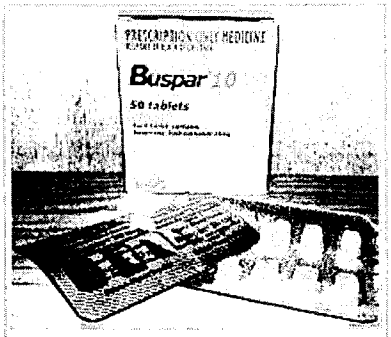
DEF030

Although not approved for this indication, studies have shown buspirone to be an effective augmentation agent alongside treatment with SSRIs (selective serotonin reuptake inhibitors) for clinical depression and is also used to counter the sexual side-effects (HSDD, anorgasmy, impotence...) of the SSRI.[10][11][12]

Several clinical trials, most randomised double-blind trials (and in one buspirone was used as an adjunct to atomoxetine) and one open-label, have been conducted to evaluate the utility of buspirone in the treatment of attention deficit hyperactivity disorder with mostly positive results.[13][14][15][16]

PubChem	CID 2477
IUPHAR ligand	36
DrugBank	DB00490
ChemSpider	2383 ✓
UNII	TK65WKS8HL ✓
KEGG	D07593 ✓
ChEBI	CHEBI:3223 ✓
ChEMBL	CHEMBL49 ✓
	Chemical data
Formula	$C_{21}H_{31}N_5O_2$
Mol. mass	385.50314 g/mol
SMILES	
InChI	

✓ (what is this?) (verify)



Buspar (buspirone) 10 mg tablets

Adverse effects

Adverse effects by incidence[1][5][6][8]

Very common (>10% incidence) adverse effects include:

- Dizziness/light-headedness
- Headache
- Somnolence
- Premature Ejaculation

Common (1-10% incidence) adverse effects include:

- Nervousness
- Insomnia
- Disturbance in attention
- Depression
- Confusional state
- Sleep disorder
- Anger
- Tachycardia
- Chest pain
- Nasal congestion
- Pharyngolaryn pain
- Paraesthesia
- Blurred vision
- Coordination abnormal
- Tremor
- Cold sweat
- Rash
- Nausea
- Abdominal pain
- Dry mouth
- Diarrhea
- Constipation
- Vomiting
- Fatigue
- Musculoskeletal pain

Uncommon (0.1-1%) adverse effects include:

- Syncope
- Hypotension
- Hypertension
- Redness and itching of the eyes
- Altered taste
- Conjunctivitis
- Flatulence
- Anorexia
- Increased appetite
- Salivation
- Rectal bleeding
- Urinary frequency
- Urinary hesitancy

Fluoxetine

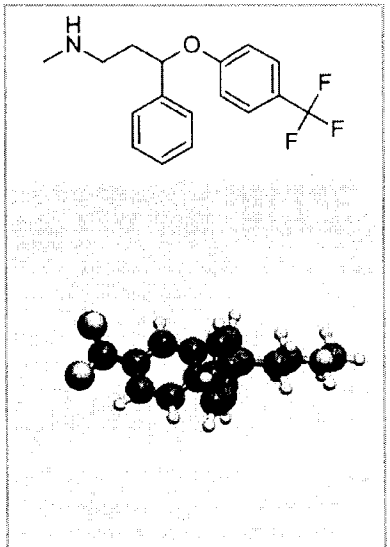
From Wikipedia, the free encyclopedia

Fluoxetine (also known by the trade names **Prozac**, **Sarafem**, **Ladose** and **Fontex**, among others) is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. Fluoxetine was first documented in 1974 by scientists from Eli Lilly and Company.[6] It was approved by the U.S. Food and Drug Administration for the treatment of major depressive disorder in December 1987.[7] The U.S. fluoxetine patent expired in August 2001 and hence generic formulations are now available in the U.S..[8]

Fluoxetine is used for the treatment of major depressive disorder (including pediatric depression), obsessive-compulsive disorder (in both adults and children), bulimia nervosa, panic disorder and premenstrual dysphoric disorder.[9] In addition, fluoxetine is used to treat trichotillomania if cognitive behaviour therapy has been unsuccessful.[10]

In 2010, over 24.4 million prescriptions for generic formulations of fluoxetine were filled in the United States,[11] making it the third most prescribed antidepressant after sertraline and citalopram.[11] In 2011, 6 million prescriptions for fluoxetine were filled in the United Kingdom.[12] It is on the World Health Organization's List of Essential Medicines, a list of the most important medication needed in a basic health system.[13]

Fluoxetine



Systematic (IUPAC) name

(*RS*)-*N*-methyl-3-phenyl-3-[4-(trifluoromethyl)phenoxy]propan-1-amine

Clinical data	
Trade names	Prozac, among others
AHFS/Drugs.com	monograph
MedlinePlus	a689006
Licence data	US FDA:link
Pregnancy cat.	C (AU) C (US)
Legal status	Prescription Only (S4) (AU) ℞-only (CA) POM (UK) ℞-only (US)
Routes	Oral
Pharmacokinetic data	
Bioavailability	72%[1]
Protein binding	94-95%[1][2][3][4][5]
Metabolism	Hepatic (mostly CYP2D6-mediated)[1][2][3][4][5]
Half-life	1–3 days (acute) 4–6 days (chronic)[1][2][3][4][5]
Excretion	Urine (80%), faeces (15%)[1][2][3][4][5]
Identifiers	
CAS number	54910-89-3 ✓ ✓
ATC code	N06AB03
PubChem	CID 3386
IUPHAR ligand	203
DrugBank	DB00472
ChemSpider	3269 ✓
UNII	01K63SUP8D ✓
KEGG	D00326 ✗
ChEBI	CHEBI:5118 ✓
ChEMBL	CHEMBL41 ✓
Chemical data	
Formula	$C_{17}H_{18}F_3NO$
Mol. mass	309.33 g·mol^{-1}

Contents

Medical uses

Fluoxetine is frequently used to treat major depressive disorder, obsessive-compulsive disorder, post-traumatic stress disorder, bulimia nervosa, panic disorder, premenstrual dysphoric disorder, and trichotillomania.[10][14][15][16] It has also been used for cataplexy, obesity, and alcohol dependence,[17] as well as binge eating disorder.[18] Fluoxetine has also been tried as a treatment for autism spectrum disorders with moderate success in adults.[19][20][21][22]

Depression

The effectiveness of fluoxetine and other antidepressants in the treatment of mild-to-moderate depression is controversial. A meta-analysis published by Kirsch in 2008 suggests that in those with mild or moderate symptoms, the efficacy of fluoxetine and other SSRIs is clinically insignificant.[23] A 2009 meta analysis by Foumier et al., which evaluated patient level data from 6 trials of the SSRI paroxetine and the non-SSRI antidepressant imipramine has been further cited as evidence that antidepressants exhibit minimal efficacy in mild to moderate depression.[24] A 2012 meta

analysis utilizing individual patient level data from 18 randomized controlled clinical trials of fluoxetine for the treatment of depression concluded that statistically and clinically significant benefit was seen irrespective of baseline depression severity, and that there was no significant effect of baseline severity on observed efficacy.[25]

Anti-psychopharmacology activist Joanna Moncrieff has argued that any improvements in mood found in trials for fluoxetine (and other SSRIs) are simply a product of an exaggerated placebo effect (regardless of the severity of depression).[26] A 2009 systematic review by the National Institute of Care and Clinical Excellence (NICE) (which considered the Kirsch but not the later meta analyses) concluded that there was strong evidence for the efficacy of SSRIs in the treatment of moderate and severe depression, and some evidence for their efficacy in the treatment of mild depression.[27] Both the NICE and the Fournier analyses concluded that there is greater evidence for the efficacy of antidepressants in the treatment of chronic mild depression (dysthymia) than in recent onset mild depression.

SMILES	
InChI	
Physical data	
Melt. point	179–182 °C (354–360 °F)
Boiling point	395 °C (743 °F)
Solubility in water	14 mg/mL (20 °C)
✗ (what is this?) (verify)	

NICE recommends antidepressant treatment with an SSRI in combination with psychosocial interventions as second line treatment for short term mild depression, and as a first line treatment for severe and moderate depression, as well as mild depression that is recurrent or long-standing. The American Psychiatric Association includes antidepressant therapy among it first-line options for the treatment of depression, particularly when there is "a history of prior positive response to antidepressant medications, the presence of moderate to severe symptoms, significant sleep or appetite disturbances, agitation, patient preference, and anticipation of the need for maintenance therapy".[28]

Obsessive-compulsive disorder

The efficacy of fluoxetine in the treatment of obsessive-compulsive disorder was demonstrated in two randomized multi-center phase 3 clinical trials. The pooled results of these trials demonstrated that 47% of completers treated with the highest dose were "much improved" or "very much improved" after 13 weeks of treatment, compared to 11% in the placebo arm of the trial.[29] SSRIs including fluoxetine should be used as first-line therapy, along with CBT, for the treatment of moderate to severe OCD.[30]

Panic disorder

The efficacy of fluoxetine in the treatment of panic disorder was demonstrated in two 12 week randomized multicenter phase 3 trials that enrolled patients diagnosed with panic disorder, with or without agoraphobia. In the first trial, 42% of subjects in the fluoxetine treated arm were free of panic attacks at the end of the study, vs. 28% in the placebo arm. In the second trial, 62% of fluoxetine treated patients were free of panic attacks at the end of the study, vs. 44% in the placebo arm.[29]

Bulimia Nervosa

A 2011 systematic review by the World Federation of Societies for Biological Psychiatry identified 7 trials comparing fluoxetine to placebo in the treatment of bulimia nervosa, of 6 found a statistically significant reduction in symptoms such as vomiting and binge eating.[31] However, no difference was observed between treatment arms when fluoxetine plus psychotherapy was compared to psychotherapy alone.

Special populations

In children and adolescents fluoxetine is the antidepressant of choice due to tentative evidence favoring its efficacy and tolerability.[32][33] In pregnancy, fluoxetine is considered a category C drug. Evidence supporting an increased risk of major fetal malformations resulting from fluoxetine exposure is limited, although the MHRA of the UK has warned prescribers and patients of the potential for fluoxetine exposure in the first trimester (during organogenesis, formation of the fetal organs) to cause a slight increase in the risk of congenital cardiac malformations in the newborn.[34][35][36] Furthermore an association between fluoxetine use during the first trimester and an increased risk of minor fetal malformations was been observed in one study.[35]

However, a systematic review and meta-analysis of 21 studies published in the Journal of Obstetrics and Gynaecology Canada concluded that, "the apparent increased risk of fetal cardiac malformations associated with maternal use of fluoxetine has recently been shown also in depressed women who deferred SSRI therapy in pregnancy, and therefore most probably reflects an ascertainment bias. Overall, women who are treated with fluoxetine during the first trimester of pregnancy do not appear to have an increased risk of major fetal malformations." But the study found also fifteen cohort studies that evaluated cardiac malformations and yielded an overall odds ratio of 1.6 (95% CI 1.31 to 1.95).[37]

Of note, the FDA states that infants exposed to SSRIs in late pregnancy may have an increased risk for persistent pulmonary hypertension of the newbom(PPHN). Limited data supports this risk, but the FDA recommends that physicians consider tapering SSRIs such as fluoxetine during the third trimester.[38] A review published in 2009 in the Journal of Human Lactation recommended against fluoxetine as a first-line SSRI during lactation, stating that fluoxetine "should be viewed as a less-preferred SSRI for breastfeeding mothers, particularly with newborn infants, and in those mothers who consumed fluoxetine during gestation."[39] Sertraline is often the preferred SSRI during pregnancy due to the relatively minimal fetal exposure observed and its safety profile while breastfeeding.[40]

Adverse effects

Side effects observed in fluoxetine-treated persons in clinical trial with an incidence that was >5% and at least twice as common in fluoxetine-treated persons compared to those who received a sugar pill include abnormal dreams, abnormal ejaculation, anorexia, anxiety, asthenia, diarrhea, dry mouth, dyspepsia, flu syndrome, impotence, insomnia, libido decreased, nausea, nervousness, pharyngitis, rash, sinusitis, somnolence, sweating, tremor, vasodilatation, and yawn.[41] Fluoxetine is considered the most stimulating of the SSRIs (that is it is most prone to causing insomnia and agitation).[42][42] It also appears to be the most prone of the SSRIs for producing dermatologic reactions (e.g. urticaria (hives), rash, itchiness, etc.).[35] A more detailed listing of adverse events observed in fluoxetine-treated patients is shown in the table below. Some of these adverse events were also seen a a large percentage of patients treated with a sugar pill.[41]

Hydroxyzine

From Wikipedia, the free encyclopedia

Hydroxyzine (/haɪˈdrɒksɪziːn/; sold as **Vistaril**, **Atarax**) is a first-generation antihistamine of the diphenylmethane and piperazine class. It was first synthesized by Union Chimique Belge in 1956 and was marketed by Pfizer in the United States later the same year,[2] and is still in widespread use today.

Due to its antagonistic effects on several receptor systems in the brain, hydroxyzine is claimed to have strong anxiolytic and mild antiobsessive as well as antipsychotic properties.[3] Today it is used primarily for the symptomatic relief of anxiety and tension associated with psychoneurosis and as an adjunct in organic disease states in which anxiety is manifested. Because of its antihistamine effects it can also be used for the treatment of severe cases of itching, hyperalgesia and motion sickness-induced nausea, it has also been used in some cases to relieve the effects of opioid withdrawal.[4][5] Even though it is an effective sedative, hypnotic, analgesic, and tranquilizer, it allegedly shares virtually none of the abuse, dependence, addiction, and toxicity potential of other drugs used for the same range of therapeutic reasons.

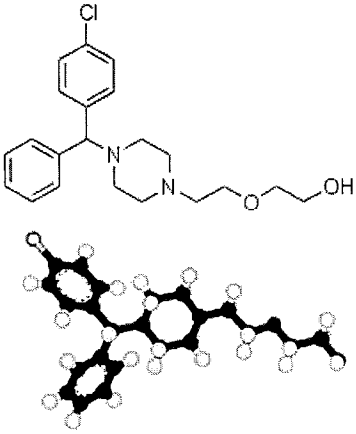
Hydroxyzine has been used in medical practice with opioid analgesics to increase the analgesic efficacy of opioids, and by recreational drug users to maximise the effects of opiates, and/or preempt some side effects of opioids like itching, nausea, and vomiting.

Hydroxyzine preparations usually require a doctor's prescription. The drug is available in two formulations, the pamoate and the dihydrochloride or hydrochloride salts. **Vistaril**, **Equipose**, **Masmoran**, and **Paxistil** are preparations of the pamoate salt, while **Atarax**, **Alamon**, **Aterax**, **Durrax**, **Tran-Q**, **Orgatrax**, **Quiess**, and **Tranquizine** are of the hydrochloride salt.

Other drugs related to hydroxyzine are cyclizine, buclizine, and meclizine, and they share all or most of the benefits, indications, contraindications, cautions, and side effects of hydroxyzine. The second-generation antihistamine cetirizine is in fact one of the metabolites of hydroxyzine produced in the human body. Unlike hydroxyzine, cetirizine is not reported to appreciably cross the blood-brain barrier, but it has been reported to be associated with dystonic reactions as well as sedation. Therefore it has a narrower spectrum of effects, making it an effective antihistamine but removing some or all of the anxiolytic and analgesic-sparing properties, but it may cause dystonic reactions and drowsiness in some patients.

Contents

Hydroxyzine



Systematic (IUPAC) name

(±)-2-(2-{4-[(4-chlorophenyl)-phenylmethyl]piperazin-1-yl}ethoxy)ethanol

Clinical data	
Trade names	Vistaril
AHFS/Drugs.com	monograph
MedlinePlus	a682866
Pregnancy cat.	A (AU) C (US)
Legal status	Prescription Only (S4) (AU) ℞ Prescription only
Routes	Oral, IM
Pharmacokinetic data	
Bioavailability	High in-vivo
Protein binding	93%
Metabolism	Hepatic
Half-life	20–24 hours[1]
Excretion	Urine, Feces
Identifiers	
CAS number	68-88-2 ✓
ATC code	N05BB01
PubChem	CID 3658
DrugBank	DB00557
ChemSpider	3531 ✓
UNII	30S50YM8OG ✓
KEGG	D08054 ✓
ChEBI	CHEBI:5818 ✓
ChEMBL	CHEMBL896 ✓
Chemical data	
Formula	

	$C_{21}H_{27}ClN_2O_2$
Mol. mass	374.904 g/mol
SMILES	
InChI	

✓ **(what is this?) (verify)**

Prescription and use

Hydroxyzine is classified as an antihistamine, antipsychotic, anxiolytic (see below) and is also used as a tranquilizer; especially common in dentistry and it retains some popularity in obstetrics, where for many years it was especially preferred for its ability to boost the effectiveness of opioids by interfering with their metabolism and subsequent elmination. as well as permit later use of scopolamine or benzodiazepines better than other drugs might.

Hydroxyzine is prescribed when the onset of an organic disease state manifests through anxiety, as generalized anxiety disorder, or in other more serious cases as psychoneurosis, and is therefore prescribed as a means of regulating normal function. Hydroxyzine has shown to be as effective as the benzodiazepine drug bromazepam in the treatment of generalised anxiety disorder.[6] Hydroxyzine can also be used for the treatment of allergic conditions, such as chronic urticaria, atopic or contact dermatoses, and histamine-mediated pruritus. These have also been confirmed in both recent and past studies to have no adverse effects on the liver, blood, nervous system or urinary tract.[7]

Use of hydroxyzine for premedication as a sedative has no effects on tropane alkaloids, such as atropine, but may, following general anesthesia, potentiate meperidine and barbiturates, and use in pre-anesthetic adjunctive therapy should be modified depending upon the state of the individual.[7]

In other cases, the usage of hydroxyzine is as a form of non-barbiturate tranquilizer[8] used in the pre-operative sedation and treatment of neurological disorders, such as psychoneurosis and other forms of anxiety or tension states.[8]

For dentistry and obstetrics as well as other surgeries and procedures and acute pain situations like accidents, hydroxyzine is useful as a first line anxiolytic and opioid adjunct because it lacks both antagonism and synergy with benzodiazepines and scopolamine, allowing either of these agents to be used simultaneously or later in the procedure if need be.

Animal behavioral research

Hydroxyzine reduced escape failures in a learned helplessness paradigm in rats.[9]

Clinical description

Metabolism and pharmacokinetics

Hydroxyzine can be administered orally or via intramuscular injection. When given orally, hydroxyzine is rapidly absorbed from the gastro-intestinal tract. The effect of hydroxyzine is notable in 30 minutes.

Pharmacokinetically, hydroxyzine is rapidly absorbed and distributed in oral and intramuscular administration, and is metabolized in the liver; the main metabolite (45%) is formed through oxidation of the alcohol moiety to a carboxylic acid by alcohol dehydrogenase, is cetirizine and overall effects are observed within one hour of administration. It has a half-life observed on average of around 3 hours in adults, with higher concentrations found in the skin than in the plasma. Cetirizine, although less sedating, is non-dialyzable and possesses similar anti-histaminergic properties. The other metabolites identified include a *N*-dealkylated metabolite, and an *O*-dealkylated 1/16 metabolite with a plasma half-life of 59 hours. These pathways are mediated principally by CYP3A4 and CYP3A5.[10] "In animals, hydroxyzine and its metabolites are excreted in feces via biliary elimination."[11]

Lisinopril

From Wikipedia, the free encyclopedia

Lisinopril (/laɪˈsɪnəprɪl/ *ly-SIN-ə-pril*) is a drug of the angiotensin-converting enzyme (ACE) inhibitor class used primarily in treatment of hypertension, congestive heart failure, and heart attacks, and also in preventing renal and retinal complications of diabetes. Its indications, contraindications and side effects are as those for all ACE inhibitors.

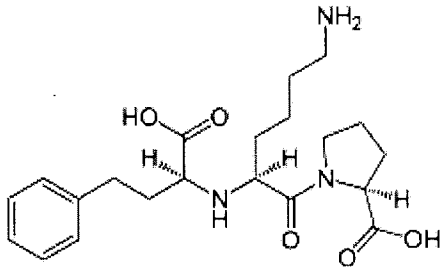
Lisinopril was the third ACE inhibitor (after captopril and enalapril) and was introduced into therapy in the early 1990s.[2] A number of properties distinguish it from other ACE inhibitors: It is hydrophilic, has a long half-life and tissue penetration, and is not metabolized by the liver.

Contents

Medical uses

Lisinopril is typically used for the treatment of hypertension, congestive heart failure, acute myocardial infarction, and diabetic nephropathy.[1]

Lisinopril



Chemical structure of lisinopril

Systematic (IUPAC) name

N^2-[(1*S*)-1-carboxy-3-phenylpropyl]-L-lysyl-L-proline

Clinical data	
Trade names	Prinivil, Tensopril, Zestril, Hipril
AHFS/Drugs.com	monograph
MedlinePlus	a692051
Pregnancy cat.	C (1st trimester) / D (2nd and 3rd trimester)[1]
Legal status	℞ Prescription only
Routes	Oral
Pharmacokinetic data	
Bioavailability	approx. 25%, but wide range between individuals (6 to 60%)
Protein binding	0
Metabolism	None
Half-life	12 hours
Excretion	Eliminated unchanged in urine
Identifiers	
CAS number	83915-83-7
ATC code	C09AA03
PubChem	CID 5362119
DrugBank	APRD00560
ChemSpider	4514933 ✓
UNII	7Q3P4BS2FD ✗

Special populations

The dose must be adjusted in those with poor kidney function.[3]

KEGG	D00362 ✓
ChEBI	CHEBI:43755 ✗
ChEMBL	CHEMBL1237 ✓
Synonyms	(2*S*)-1-[(2*S*)-6-amino-2-{[(1*S*)-1-carboxy-3-phenylpropyl]amino} hexanoyl]pyrrolidine-2-carboxylic acid
PDB ligand ID	LPR (PDBe, RCSB PDB)
Chemical data	
Formula	$C_{21}H_{31}N_3O_5$
Mol. mass	405.488 g/mol
SMILES	
InChI	

✗ **(what is this?) (verify)**

Adverse effects

Side-effects, some of which are serious and require immediate medical attention, may include:[4]

- Chills, signs of infection
- Dark urine, decreased urination (oliguria)
- Difficulty swallowing or breathing (signs of angioedema), allergic reaction (anaphylaxis)
- Hoarseness
- Itching
- Yellowing of skin or eyes (jaundice)
- Abdominal pain, bloating, vomiting
- Chest pain or tightness, dizziness, lightheadedness, fainting (syncope)
- Dry cough
- Fever
- Joint pain
- Rash
- Diarrhea, nausea
- Drowsiness, headache, tiredness
- Muscle cramps
- Dry mouth
- Serious (possibly fatal) liver problems
- Impotence[5]
- Fainting or brief loss of consciousness*NHS Choice website quote

Lisinopril causes the kidneys to retain potassium, which may lead to hyperkalemia. From a study on eHealthMe of more than 1,000 patients with hyperkalemia when using it, the condition may happen more in older male users.[6]

A rare but severe allergic reaction that affects the bowel wall and secondarily causes abdominal pain can